DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Home Health Agencies
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No: 03-22 MAA
Issued: June 30, 2003

For Information Contact:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 02-52 MAA

Subject: Home Health Program: Fee Schedule Update and Discontinued State-Unique Revenue Codes

Effective for dates of service on and after July 1, 2003, the Medical Assistance Administration will implement the following:

- Maximum allowable fees for the Home Health Program will remain at their current levels; and
- State-assigned revenue codes will be discontinued.

Maximum Allowable Fees

The 2003 Washington State Legislature **has not appropriated a vendor rate increase** for the 2004 state fiscal year. Therefore, the maximum allowable fees for the Home Health Program will remain at their current levels.

Discontinued Codes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. MAA is discontinuing state-unique codes and modifiers and will require the use of applicable CPT™ and HCPCS procedure codes on all submitted claims.

Continued on next page…

MAA currently allows the use of state-unique revenue codes to describe services for the Home Health Program. **Effective for dates of service on and after July 1 2003**, the following state-unique codes are discontinued:

Discontinued State-Unique Revenue Code	Description	Replacement Revenue Code	Restrictions
558	Skilled, High-Risk Obstetrical Nursing	551	Diagnosis code must be V23 or 630-670 and high-risk criteria are met. **Limited to** 3 visits per client per pregnancy.
590	Flu Vaccine	No Replacement	NA

Bill MAA your usual and customary charge. Reimbursement will be the lower of the billed charge or the maximum allowable fee.

Replacement pages D.3/D.4, G.7/G.8, and H.1/H.2 are attached for MAA's Home Health Billing Instructions, dated September 2002.

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

c. **Home Infusion Therapy -** only if the client:

- Is willing and capable of learning and managing the client's infusion care; **or**
- Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

ε **Note:** MAA does not reimburse administration of IV therapy through the Home Health program. MAA does reimburse for the teaching of IV therapy and skilled observation of IV site through the Home Health program.

ε **Note:** All other infusion therapy related services must be billed on a HCFA-1500 claim form using the InfusionTherapy Billing Instructions (see Important Contacts).

Note:
Although DSHS clients may have a paid caregiver who is willing and capable of performing the skilled task, as a paid caregiver they may not be paid for this service. The client may want to be involved in self-directed care [Refer to WAC 388-71-0580].

d. **Infant Phototherapy** – for an infant diagnosed with hyperbilirubinemia:

- When provided by an **MAA-approved*** infant phototherapy agency; **and**
- For up to **five (5)** skilled nursing visits per infant.

ε **Note:** If the infant's mother is enrolled in an MAA managed care plan at the time of the birth, you must receive approval from the managed care plan listed on the mother's DSHS Medical ID card. **Do not bill MAA for these services.**

Additional Information Required in the Plan of Care
(See page E1 and E2 for a complete list):

- Infant's name, **mother's** name, and PIC(s);
- Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy;
- Name of hospital where infant was born and discharge date;
- Visit notes that include family teaching and interventions; **and**
- Bilirubin levels.

***How do I become an MAA-approved infant phototherapy agency?**

- Be a Medicaid and Medicare certified Home Health agency;
- Have an established phototherapy program; and
- Submit to MAA for review, all of the following:

  - ✓ Six months of documented phototherapy services delivered for infants;
  - ✓ A written policy for home phototherapy submitted to MAA for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health; **and**
  - ✓ Three letters of recommendation from pediatricians who have utilized your program.

ε **Note: MAA will not cover** infant phototherapy, unless your agency has a pre-approval letter on file from MAA noting that you are an MAA-approved infant phototherapy agency. Refer to MAA's Durable Medical Supplies & Equipment Billing Instructions for equipment component.

e. **Limited High-Risk Obstetrical Services**:

- For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

- For up to **three** home health visits per pregnancy, if:

  - ✓ Enrollment in or referral to the following providers of First Steps has been verified:

    - ➢ Maternity Support Services (MSS); **or**
    - ➢ Maternity Case Management (MCM); **and**

  - ✓ The visits are provided by a registered nurse who has either:

    - ➢ National perinatal certification; **or**
    - ➢ A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

ε **Note:** Use revenue code **551** with diagnosis codes V23 or 630 through 670 when billing for skilled high-risk obstetrical nursing care visits in the home setting.

MAA does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See Section F - MAA's Specific Criteria for High-Risk Obstetrical

Common Explanation of Benefits (EOB) Denial Codes for the Home Health Program

The Remittance and Status Report (RA) you receive back in the mail may list one or more of the following EOB codes.

EOB Code	Explanation of EOB Code
041	**Duplicate of claim or service** previously paid. Also, used if twice a day visits have been billed and there are no orders to cover the second visit.
043	**Sent to MAA's Home Health Program Manager** Do not rebill.
061	**Bill Medicare A.** If not Medicare eligible, submit justification to Home Health Program Manager and rebill.
068	**Bill Medicare B.** If not Medicare eligible, submit justification to Home Health Program Manager and rebill.
370	**Services do not meet the Medicaid Home Health criteria.** If you have supporting justification, submit documentation to the Home Health Program Manager and rebill.
373	**Medical review by MAA**. Call MAA's Home Health Program Manager at (360) 725-1676.
385	**Your Plan of Care was received, however updated M.D. orders/clinical notes are needed to justify treatment.** Example: One wound assessment needed for each month wound care is billed or documentation of reason home health is needed.
506	**Telephone confirmation** Claim or line item has been corrected.
591	**Visits billed exceed plan of care.** Submit physician change orders to cover the visits to the Home Health Program Manager and rebill.
592	**No (current) plan of care on file.** Please submit a plan of care to the Home Health Program Manager and rebill.

Medical Review Rebilling:

- Prior to rebilling, please cross off all lines on the claim form that MAA has already paid.
- During your review period, if you receive a denial for payment and you have the supporting documentation, follow the criteria in Section E, then send the bill and appropriate documentation to:

ATTN: Special Handle
Home Health Program Manager
PO Box 45506
Olympia, WA 98504-5506

Fee Schedule

The following rates are established for the two regional classifications of home health agencies: Metropolitan Statistical Area (MSA) and Non-Metropolitan Statistical Area (Non-MSA). The rates are as follows:

July 1, 2003

	Skilled Nursing Intervention/ Skilled, High-Risk Obstetrical Nursing	Brief Nursing Visit	Physical Therapy	Speech Thrpy	Occupational Therapy	Home Health Aide
Revenue Code:	0551	0580	0421	0441	0431	0571
METROPOLITAN STATISTICAL AREA – RATES PER VISIT						
Bellingham	$87.40	$19.20	$78.99	$85.79	$81.34	$47.89
Bremerton/ Kitsap	77.14	19.20	69.71	75.71	71.85	42.29
Olympia	83.16	19.20	75.17	81.63	77.42	45.58
Richland/ Kennewick	79.87	19.20	72.21	78.41	74.37	43.82
Seattle/ Everett	88.07	19.20	79.60	86.44	81.96	48.25
Spokane	87.83	19.20	79.49	86.33	81.85	48.20
Tacoma	84.81	19.20	76.65	83.26	78.94	46.49
Vancouver	88.24	19.20	80.04	86.94	82.41	48.54
Yakima	80.70	19.20	72.89	79.23	75.14	44.22
NON-METROPOLITAN STATISTICAL AREA – RATES PER VISIT						
Non-MSA	$87.73	$19.20	$82.36	$89.11	$90.16	$42.22

***** Home health agency providers may receive reimbursement for administering flu vaccine injections to appropriate MAA clients at sites such as senior and neighborhood centers.

NOTE:
These rates are the most current rates and are effective for dates of service on and after July 1, 2003.

How to Complete the UB-92 Claim Form

General Instructions

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).
The numbered boxes on the UB-92 are called ***form locators***. *Only form locators that pertain to MAA are addressed here*. If you are billing electronically, use claim type ***"P" - Medical Vendor***.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR, DESCRIPTOR AND INSTRUCTIONS:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with MAA.

3. **Patient Control Number** - Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number*.

4. **Type of Bill** - Enter **33** plus one of the following as the third digit:
- **1** = Admit through discharge
- **2** = Interim, first claim
- **3** = Interim, continuing claim
- **4** = Interim, last claim

6. **Statement Covers Period**

A. Enter the beginning and ending service dates for the period included on this bill.
B. For all services received on a single day, enter the date in both the "from" and "through" areas.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on his/her DSHS Medical Identification card.

13. **Patient Address** - Enter the client's address.

14. **Birthdate** - Enter the client's birthdate.

17. **Admission Date** - Enter the date services began (MMDDYY).

24. **Condition Codes** - Enter the appropriate code from this list:

Insurance Codes

01	=	Military service related condition
02	=	Employment related condition
03	=	Patient covered by insurance not reflected here
04	=	Lien has been filed

42. **Revenue Code** - Enter the appropriate revenue code(s) from the following list.

Revenue Code	Description
421	Physical Therapy
431	Occupational Therapy
441	Speech Therapy
551	Skilled nursing intervention (includes high risk obstetrical)
571	Home Health Aide
580	Brief nursing visit

43. **Description – Revenue Code(s)** - Enter a narrative description of the detailed revenue codes by date of service. For more efficient and accurate processing, you must follow the steps below:

A. When billing a span of dates, only consecutive days may be billed on a single line entry.

B. When billing non-consecutive days, only two dates of service may be billed per line.

C. When **multiple** services are performed on the **same day**, the second service must be billed on a **separate line**. If there are two items within the same line, both of the items will be denied.

D. A maximum of 21 lines is allowed per claim.

46. **Service Units** - Enter the appropriate units or days.

47. **Total Charges** - Enter the charge for each line. Enter *"Total Charges"* on the last detail line 23.

50. **Payer Identification: A/B/C** - Enter all health insurance benefits available.

50A: Enter **Medicaid**
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51. **MAA Provider Number** - Enter the provider number issued to you by MAA. This is the seven-digit provider number that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.

54B: Enter any prior payments from payor listed in form locator 50B.

54C: Enter any prior payments from payor listed in form locator 50C.